NCCEP
North Carolina College of Emergency Physicians

Chapter News

North Carolina College of Emergency Physicians

October 2025

In This Issue

President's Message

As we continue to navigate the ever-evolving landscape of health care, I want to take a moment to recognize the challenges we face and reaffirm our commitment to advocating for you — the emergency physicians on the front lines — and for the patients who depend on us.

The COVID-19 pandemic may have officially receded from headlines, but its effects remain deeply felt in our emergency departments. Issues such as patient boarding, provider burnout, workplace violence, nursing shortages, reimbursement instability, and scope of practice concerns have only intensified over the past four years. These are not new problems, but they have become more urgent and visible than ever before.

Progress can feel slow at times, especially when the challenges are steep. But we are moving forward. Every conversation, every piece of legislation, every advocacy effort brings us closer to a more sustainable and humane practice environment.

We know there are still many mountains to climb. But we are climbing them — together. And we will continue to work relentlessly to create a better environment not only for our members, but also for the patients we are privileged to care for.

Thanks,
Melanie Artho, MD, FACEP
President, North Carolina College of Emergency Physicians

Legislative Update

By: Colleen Kochanek, JD
NCCEP Lobbyist and Executive Director

Usually when session ends, we have fewer advocacy items to work on but this year we have been busier than ever dealing with potential physician reimbursement cuts for Medicaid and a law enforcement bill with a provision about violent offenders being taken to emergency departments. Let's take these one at a time.

MEDICAID
Each year DHHS provides an amount that is needed for the Medicaid rebase – which is the number needed to keep all programs and reimbursement rates the same for the next year. Usually funding the rebase is not controversial and is included in the budget each year. This year since the House and Senate have not been able to reach an agreement on the budget, the chambers have worked on "mini-budgets" to provide funding for critical items – like the rebase. Although DHHS said that they needed $819 million for the rebase, the House and Senate provided $600 million and $100 million was for administrative costs.

A few months after the mini-budget was approved the department sent out a summary of reimbursement and program cuts that would be a minimum of 3% for all and up to 10% for many, including emergency medicine. The department argued that they would run out of money and had to plan ahead and make cuts now in anticipation. The House and Senate were not pleased and felt that the department had plenty of funds and should allow the General Assembly to work on the budget. A resolution was worked on prior to the September session and it looked like an agreement would be reached as the House and Senate both agreed that more money needed to be provided for the rebase and it appeared that the department was in agreement that this new funding would be sufficient to prevent the cuts from being implemented.

But that would be too logical and straightforward! The talks broke down as the House wanted a "clean bill" with only the rebase issues included, and the Senate wanted to include funding for the children's hospital that is planned for Wake County and also funding for NC Cares which helps rural areas of the State. The chambers are at an impasse even though they generally agree on the amount of funding needed for the rebase. Both the House and the Senate though are blaming the Governor and the Department for moving forward with cuts they say are not needed at this time – they argue that there is plenty of money to continue and allow the legislature the time to resolve the issue.

With all of that in the background the cuts went into effect on October 1 st – cuts no one wants and everyone agrees should not happen. One of the most frustrating situations I have ever been involved in during my career. Physician and provider groups continue to put on pressure to resolve this issue – please continue to reach out to your legislators and the Governor's office about this critical issue.

Involuntary Commitment
Also during the September legislative session, the prior provisions of House Bill 307 were stripped out and a new bill was presented to address law enforcement issues after the tragic murder in Charlotte. The legislation was crafted behind closed doors, and it appears that neither health care leaders and/or medical or mental health professionals were consulted about the language. Although the bill primarily deals with law enforcement issues, there is a troubling provision that would require law enforcement to bring violent offenders who have previously been subject to an order of involuntary commitment within the prior three years or is a danger to themselves or others, to be immediately taken to an emergency department or other crisis facility for an initial examination. We immediately spoke to Rep. Reeder and the Speakers office and also reached out to leadership in the Senate about our concerns; however, the bill was fast-tracked (released on Monday and approved by the Senate and approved by the House the next day) for passage in light of the politics and the press regarding the situation.

The bill was approved by both the House and the Senate and signed into law by the

Governor earlier this week and the provision that we are concerned about is effective December 1, 2025. However, we have been given assurances by both the House and the Senate that they will address our concerns. In the Senate we have been working with Sen. Berger's office and on the House side they have announced a Select Committee on Involuntary Commitment and Public Safety which will be chaired by Rep. Reeder and Rep. Blackwell. The North Carolina College of Emergency Physicians have also formed an IVC Task Force to provide information to legislators and to work on practical solutions to improve the IVC process, increase safety in emergency departments and reduce the boarding of behavioral health and IVC patients. If you have ideas or suggestions, please feel free to send those to me or anyone on our executive committee.

ACEP Council Update

By: Sierra Gilder, MD

This September, our NCCEP Councilors convened in Salt Lake City for the annual ACEP Council meeting. As the NCCEP Leadership & Advocacy Fellow, I had the opportunity to attend Council for the first time. It was an informative experience, and I'm excited to share what I learned!

The Council is composed of representatives from each state, and other relevant stakeholders, including subspecialties like Pediatrics and Wilderness Medicine, the Council of Emergency Medicine Residency Directors (CORD), and the Emergency Medicine Residents' Association (EMRA). Over the two-day meeting, the Council debated and voted on numerous resolutions, and held elections for ACEP President-Elect, Board members, and Vice Speaker.

In the months leading up to the Council meeting, members put forward resolutions on a range of topics- such as whether we support having an EM trained physician in every Emergency Department and if the College should be more vocal in support of DEI initiatives. Our members reviewed and commented on these resolutions during our August NCCEP board meeting. These comments were then sent to one of three Reference Committees, where a group of Councilors compiled and summarized the feedback. Our first day in Salt Lake, our councilors divided up to attend the three Reference Committee sessions. Councilors could request that specific resolutions be pulled for debate, while the remaining items were grouped together for approval by consensus. For the controversial items, Councilors could offer additional arguments either in favor of or against a resolution. It was a bit surprising to see which items were debated most contentiously. That evening, our chapter enjoyed a delicious dinner and drinks, sharing highlights from each committee session to ensure everyone was informed on all the major topics. The next day, the full Council reconvened for voting. First, many resolutions were passed together by consensus, while those that had been debated were brought to the floor for further testimony. The Council then voted to approve, reject, or refer each item to the ACEP Board for additional consideration. It was a long but productive day!

As part of the Council meeting, we also elected the new ACEP President-Elect, Ryan Stanton, Council Vice Speaker Larissa Traill, and Board members including incumbent Kristin McCabe-Kline and new members Steven Kailes, Bing Pao, and Daniel Freess.

That evening, our chapter hosted a lively reception and meet & greet with our ACEP Board Members, Abhi Mehrotra and Jennifer Casaletto, which was widely attended and considered the place to be that night over several competing events. We were also able to celebrate 15 years with Colleen as our incredible Executive Director. It was a lovely way to close out the weekend prior to the start of the ACEP Scientific Assembly.

The 2025 Council considered 91 resolutions: 67 were adopted, 13 were not adopted, 1 was withdrawn, and 8 were referred to the Board of Directors and 1 was referred to the Council Steering Committee.

Here is a summary (you will need to login to view) of all resolutions considered by the Council and the resolutions requiring action by the Board of Directors, including the referred resolutions. The two Bylaws resolutions that were adopted by the Council were adopted by the Board and the 65 non-Bylaws resolutions adopted by the Council were accepted by the Board on September 10 without any changes. *Note: Amended Resolution 45 Comprehensive Support for Medicaid and Consolidation of ACEP Medicaid-Related Policies was adopted in lieu of Resolutions 45 and 46.*

Elections for the Council Officers, Board of Directors, and President-Elect were also held:

- Speaker: Michael McCrea, MD, FACEP
- Vice Speaker: Larisa Traill, MD, FACEP
- President-Elect: Ryan Stanton, MD, FACEP
- Board of Directors: Dan Freess, MD, FACEP; Steve Kailes, MD, MPH, FACEP; Kristin McCabe-Kline, MD, FACEP (incumbent); Bing Pao, MD, FACEP

The next Council meeting is October 3-4, 2026 (Saturday-Sunday) in Chicago, IL.

Upcoming Events

Board Meeting - 01/21/26 (Zoom)
ED Operations Summit - 03/27/26 (Greensboro)
Board Meeting - 04/15/2 (Greensboro)
ACEP LAC - 04/26/26 - 04/28/26 (Grand Hyatt, Washington, DC)
Board/Membership Meeting - 06/03/26 (Kiawah Island, SC)
Coastal EM Conference, 06/04/26 - 06/06/26 (Kiawah Island, SC)
Fall Conference - 11/02/26 - 11/05/26 (Grove Park Inn, Asheville, NC)

*If you would like to participate in the Zoom Board meeting(s), please e-mail us for login information.

Coastal EM Conference - June 4-6, 2026

Save the Date! The 2026 Coastal Emergency Medicine Conference will be held June 4-6, 2026, once again in Kiawah Island, SC. Registration will be open soon!

Reception for Dr. Tim Reeder

NCCEP, WEPPA and MEMA held a very successful fundraiser for Rep. Reeder last month that was well attended by emergency physicians. We raised almost $20,000 for Rep. Reeder's campaign. IF you missed it, please consider making a contribution **HERE**. Having an emergency physician in the General Assembly makes all the difference for our issues and Rep. Reeder has been a strong advocate and tireless leader.



Thriving in the Fire: Crisis Leadership in the

ED

By: Bret Nicks, MD, MHA, FACEP

In emergency medicine, crisis isn't an occasional visitor; it's our constant companion. We live in the rhythm of alarms, uncertainty, and controlled chaos, running *into* the fire when others run away. Yet even those trained for the storm need deliberate leadership practices to stay grounded and guide others when everything around us remains uncertain.

You may have heard it said that everything rises and falls on leadership. I believe there is truth in that statement. In moments of crisis, our leadership defines the tone, the culture, and the outcomes — both clinical and with our teams. Whether it's a mass casualty event, an unexpected crash airway, or the emotional exhaustion of a relentless shift, great leaders don't react — they respond with purpose.

Below are **three practical applications** distilled from the insights of leadership thought leaders for those of us who lead through crisis every day. Stand fast. You are never alone.

1. Lead With Calm and Clarity

In chaos, emotions amplify uncertainty. The leader's tone sets the team's thermostat. When everyone else's pulse is racing, lower yours. Speak slowly. Breathe intentionally. Name the next clear step. Groeschel teaches that clarity trumps certainty — you may not know everything, but if your team knows *what to do next*, they will move forward together. People follow calm and clarity, not chaos.
Practice: This is likely a common practice for many already. Before every high-acuity resuscitation or code, pause for a 10-second "huddle." Recenter the team around the following: *Here's what we know, define roles, and lead with confidence.* Creating a shared moment after each event to debrief creates opportunities for learning and closure.

2. Extreme Ownership and Accountability

Crisis leadership demands ownership of the decision, the tone, and the outcome. For those who have read Willink's principle of *Extreme Ownership, this* means no excuses, no blame, only responsibility. As a leader in the ED, you set the stage and the tone for leadership and expectations. That means taking ownership not just for actions (or inactions), but for team communication, morale, and follow-through. It also includes those difficult (and often missing) conversations with teammates, patients, and families.
Practice: Set the tone for each shift. Acknowledge your teammates and the state of the department as you start your shift. Encourage open communication and lead by example. Remain open to inquiring from others, *"What could I have done better as the team leader?"* This vulnerability builds trust, fosters learning, and models accountability.

3. Lead With Purpose, Not Power

Sinek teaches that people don't buy *what* you do; they buy *why* you do it. In crisis, purpose fuels resilience. Maxwell reinforces that leadership is influence — earned through service, not position. Our purpose as emergency physicians isn't just to fix physiology; it's to restore hope in moments that feel hopeless. That is not just for our patients and their families, but also for our team.

Practice: Reconnect your team to the "why." In the lull after a chaotic shift, remind them: *"What we did tonight mattered. We were light in someone's darkest hour."* Connecting with purpose helps keep the tank full and reframes the effort as meaningful, rather than just a job.

Final Thought

Crisis doesn't build character — it reveals it. In the crucible of the emergency

department, our leadership ripples outward. Lead with calm, take ownership, and serve with purpose. When we run into (or continue to work within) the fire with clarity and courage, we don't just save lives — we ignite hope.

Other News & Information

Membership Renewal

Please be sure to renew your NCCEP membership! We rely on membership dues to keep our Chapter running and provide advocacy, education and a place to share experiences and issues with other emergency physicians. If you have not yet renewed for this year, you may do so here.

Political Action Committee

Thank you to all members who have contributed to the College's Political Action Committee (EP-PAC) over the past year and to those who continue to contribute in 2025. Your donations allow the College to work on your behalf to give a voice to Emergency Medicine issues in our State Legislature.

You may contribute to the EP-PAC online, by mail to EP-PAC, PO Box 1038, Wake Forest, NC 27588, or on your ACEP dues renewal form.

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